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Original Communications.

CASE OF STRANGULATION OF THE LARGE INTESTINE, NEAR THE JUNCTION OF THE DESCENDING COLON AND THE SIGMOID FLEXURE, BY A BAND,

SUCCESSFULLY TREATED BY AN OPERATION.

By Dr. R. LAWRENCE WILDER, San Francisco, Cal.

MARCH 30th, 1868, was called to see Mr. G., aged 33, in consultation with Dr. J. D. B. Stillman. Found patient vomiting incessantly a thin, coffee-colored fluid. He had had no passage from the bowels for four days. There was some swelling of the abdomen, and considerable tympanites. Great pain on pressure; countenance pale and anxious; pulse 130, thready and irregular. There were no appearances of hernia. The patient referred his pain mostly to the *right iliac fossa*. This, with the suddenness of the attack, led us to believe that the trouble was intussusception at the ileo-cæcal valve.

Warm-water injections had been given every hour for the previous twenty-four hours, but had come away without apparently entering the colon. Insufflation was then proposed. Quite a large amount of air was pumped in, by means of a Davidson's syringe. We suffered this air to remain in for a time, in hopes that by distending the intestine gently but fully, we might be able to bring things to a normal position and condition.

The air gave the patient so much pain that in about an hour it was thought advisable to allow it to escape. On dilating the sphincter ani, no air escaped. The rectum and sigmoid flexure remained perfectly empty, while the whole extent of the colon remained distended. This turned our attention to the *real* cause of all these symptoms of obstruction, which we decided must be a stricture of the large intestine, situated near the junction of the descending colon and the sigmoid flexure. It also seemed most probable that this obstruction

was caused by a band of adhesion, suddenly inflamed; for the patient had had peritonitis about two years before, and had since, as he says, been troubled with "colic."

A long enema-tube, carefully passed up, met with a decided obstruction about eighteen inches from the anus. After several attempts to pass the tube into the colon, which were unsuccessful, the tube being stopped at the same place each time, we decided that his only hope of relief lay in an operation.

Later in the day, Dr. Calvin G. Page, of Boston, Mass., saw the patient with us, and, after a careful examination, agreed as to the diagnosis, and fully concurred with us in the opinion that an operation for the relief of the stricture afforded the patient his only chance of recovery. This statement being made to the patient and his friends, they consented to anything we might propose to do. As it was late in the day, and as the symptoms were about the same as in the morning, we determined to postpone operative interference until the next day—in the meantime to give the patient the benefit of treatment by position.

March 31st.—The previous symptoms being more marked, and the abdomen having become more tympanitic and enlarged, the operation was immediately decided upon.

Operation, by Dr. Wilder, assisted by Drs. Stillman and Page. Patient etherized and placed upon his right side. Incision made about midway between the last rib and the crest of the ilium, commencing at the edge of the sacro-lumbar and long dorsal muscles, and extending horizontally towards the umbilicus about four inches. The muscles were then carefully divided on a director, in both directions, the entire length of the incision. A large amount of fat appeared and rolled up into the opening. This I carefully dissected through with my finger and the handle of my scalpel. The distended intestine now showed itself in the aperture. I carefully passed my hand into the cavity of the abdomen, through the incision, and at the same time introduced an olive-pointed œsophageal

[WHOLE No. 2108.]

probang into the rectum *per anum*. Carefully following this, with my finger within the abdominal cavity, I passed the probang along till I arrived at the stricture, which was found to be at the junction of the colon and sigmoid flexure. The intestine below the stricture was loose and flaccid, while above there was great distention, feeling like an inflated bladder with a string tied around its neck. I felt what seemed to be a *fibro-membranous band* surrounding the intestine and constricting it. By pushing the point of the probang well up, and using my finger-nail, I succeeded in dividing the stricture. Immediately upon the division of the band, the probang slipped through into the colon; at the same time an immense amount of gas and fluid feces escaped with great force from the anus. A long enema-tube was then introduced, which passed easily up the descending colon, through which more gas escaped. Drs. Stillman and Page also satisfied themselves, by an examination, that the stricture was divided, and that the tube passed freely up the descending colon. I now withdrew the tube. The flaps of the wound were brought together and the edges held by sutures. Strips of adhesive plaster and a roller were then applied.

Only one vessel was divided, and that was a small muscular branch, scarcely requiring a ligature. The hæmorrhage amounted to nothing. The depth of the dissection and the care necessary, made the operation rather long and tedious. Ordered two ounces of brandy, to be immediately given by the mouth.

9.30, P.M.—Patient rallied well. Passes gas *per anum*. Tympanitis diminished very much. Pulse 110, regular and strong. Ordered morphia sulph. gr. ss. subcutaneously.

April 1st, 12.30, A.M.—Patient comfortable. Pulse 110. Repeat morphia.

7, A.M.—Patient is very comfortable. Pulse 110, strong and regular. Tympanitis still diminishing. Countenance cheerful. There has been no vomiting since the operation. Ordered beef-tea, four ounces, to be injected into the rectum. Ice to allay thirst, which is considerable. To repeat morphia.

12.30, P.M.—Pulse 96. Patient complains of pain in right thoracic region. Has previously had rheumatism. Ordered, lemon to suck. To chew beef-steak, as he says he feels very hungry. Repeat morphia, and continue ice.

6, P.M.—Pulse has risen to 110. Tympanitis remains about the same. Ordered,

hop fomentations to be applied over whole abdomen. Repeat morphia.

12, M.—Pulse 120, not so strong. Some delirium. Coma vigil. Patient complains of seeing cobwebs, &c., about the room, and is wandering in his speech. Tongue dry and horny. Removed the dressing from wound. Incision entirely closed by first intention. Ordered, brandy 3ss. every hour; also R. Ferri et quinae citratis, ʒij.; syrup. aurantii, ʒi.; aque fontane, ʒiv. M. To take two teaspoonsful every two hours. Repeat morphia, gr. i.

April 2d, 8, A.M.—Patient more comfortable. Pulse 120. Respirations 40. Tympanitis so much increased as to impede the movements of respiration. Tongue looks better. Horny feeling gone. Brandy to be reduced to two teaspoonsful every hour. Ice to suck. Morphia gr. i. repeated.

6, P.M.—Considerable delirium. Tympanitis very great. Decided, on recommendation of Dr. Page, to puncture the peritoneum and let out the gas. Pulse 120; respirations 45, just previous to the operation. I introduced a small trocar in the median line into the sac of the peritoneum, just below the umbilicus. A great amount of gas rushed out, relieving the distention below, but not above the umbilicus. Another perforation was made with the trocar, about two inches above the umbilicus in the median line. A much larger amount of gas escaped than from the puncture below. The abdomen at once became flattened and more natural. The pulse came down to 100 per minute, and remained stronger and more regular. The respirations were reduced to 34. Repeated morphia gr. i. Ordered to continue brandy and prescription.

12, M.—Was suddenly called to see patient. Found him with delirium of an epileptiform character. Pulse 130. Pupils dilated. Ordered to discontinue morphia and the prescription also. To have potass. bromid. ʒij. To continue brandy.

3d.—Patient very much better. Very rational at intervals. Tongue clean and soft. Pulse 100, strong and regular. Tympanitis entirely disappeared. Very little tenderness on pressure of abdomen. Wound entirely united, firm and sound. Patient seems generally very much improved. Potass. bromid. ʒij.

4th.—Pulse 90, strong and regular. Patient has had three profuse alvine evacuations, blackened by the iron previously administered. Slight delirium present, which is of an epileptiform character. Patient

has been accustomed to have these attacks since his youth. To continue bromide of potass. Beef-tea and milk *ad libitum*.

7th.—Removed sutures. Union firm the whole line of the incision. Appearance of abdomen perfectly natural. Bowels regular. Delirium gone. Pulse 84, soft and compressible. Patient in every respect convalescent. There is nothing in the condition of the abdominal parts to prevent a rapid recovery.

The case above narrated by Dr. Wilder terminated fatally a few days after the conclusion of his report, death occurring from pyæmia.

There are two points in the case that should go upon the record. The first is, that the patient was subject to occasional attacks of epilepsy and had suffered some years previously from a fall through a scuttle, a distance of three stories, since which accident he had had frequent attacks of abdominal pain in the region of the liver. The *post-mortem* appearances in this region showed old peritoneal inflammation, with adhesions to the diaphragm, and a recent deposit of lymph and pus over a surface of several inches, but entirely confined to that region.

The second point is, the great relief given by puncturing the peritoneum with the trocar and allowing the accumulated gases to escape. I examined the peritoneal points of puncture *post mortem*, and found no trace of inflammation. The intestines were not touched by the trocar.

The intestine at the point of stricture showed an ecchymotic line an inch long by one fourth inch wide, but was otherwise healthy. There was considerable pus found behind the peritoneum, between it and the line of incision, which had closed by first intention. It would, perhaps, have been better to have kept the most dependent part of the wound open, so that this pus could have escaped.

CALVIN G. PAGE.

PELVIC CELLULITIS.

By H. O. MARCY, M.D., Cambridgeport.

INFLAMMATION of the cellular or areolar tissue of the pelvis occurs so rarely, except in connection with the puerperal state, external violence, or uterine disease, that cases of idiopathic character are of more than ordinary interest. The obscurity of diagnosis, and departure from the usual prescribed rule of surgical non-interference,

have caused me to feel that the following case was worthy of record.

Mrs. S. K., aged 33; first seen in October, 1867. Mother died of ovarian tumor. Father living. In early life, healthy. Menstruated at 16; married at 17. One child, 12 years old. Severe labor. Delivered by turning. Sick for weeks. Troubled at times with prolapsus. Has worn supporters. Never pregnant since.

In January, 1867, had pneumonia. During attack suffered from severe pain in lower part of bowels; later, noticed a swelling in left iliac region, size of an orange; quite tender and painful. Tr. iodine was applied externally by attending physician. It was thought to have disappeared, but some time later was again noticed, and has been constant since, gradually increasing in size up to the present.

In May had a discharge of several ounces of very fetid pus by rectum. Pus has been discharged several times since from rectum, each time preceded by increased suffering. Has occasionally noticed fæces covered with pus.

Present condition, October, 1867. Pale, anæmic; much loss of flesh and strength. Appetite good, bowels inclined to diarrhœa. Sleeps poorly; complains of much pain about the tumor, shooting down leg. At times compares the suffering in severity to that of labor. Dull heavy pains in entire pelvic region.

By abdominal examination there can be distinctly felt above the pubes on left side, a hard non-fluctuating mass, rounded in outline, not differing much in size from a child's head at birth. Os uteri enlarged, thickened, rough, admitting finger.

Posteriorly and apparently continuous with the fundus uteri is felt the tumor above described, dipping down into the pelvic basin. The uterus above the cervix seems lost in the mass.

Examined from the rectum, that portion within reach feels softer, is partially separated from the mass above, by constricting fibrous bands, giving it a bilobulated appearance. Has menses quite regularly, but excessive menorrhagia, usually from two to three dozen napkins.

The patient "has been the rounds of the Doctors." The larger number have not hesitated to pronounce it cancer, and advised non-interference.

At my request the patient consulted my friend, Dr. H. R. Storer. His diagnosis was fibroid tumor of the uterus—that pressure and irritation were the probable causes

of the purulent discharges from the bowels. By his direction the os uteri was dilated with sponge tents. Interior uterus healthy.

Early in December, the pains increased, the suffering became very severe; patient confined to bed. The lower portion as felt from the rectum rapidly increased in size, and became very tender to the touch. A spontaneous discharge of pus from the bowel took place, lessening somewhat this portion of the mass.

Profiting by this hint of nature, and believing that a chronic abscess was at least part of the trouble, at my request Dr. Storer passed an exploring trocar, on the 15th, from the vagina and obtained pus; an opening was made, by which a small quantity of pus escaped. This opening closed in a few hours.

Four days later, I etherized the patient, and entered a large curved trocar posteriorly, and to the left of fundus uteri, and drew off about 20 oz. of thick, fetid pus.

My firm unyielding tumor of 12 months standing softened and disappeared, leaving only a thick indurated sac, which was enlarged to admit the finger, by cutting with a bistoury entered from the opening made by trocar. A profuse discharge of purulent secretion continued. The sac was washed out daily with warm water, after which a solution of carbolic acid was thrown in.

Kept the opening from closing, by applying a silver female catheter to which a piece of flexible rubber tubing was attached. This was readily retained by a napkin, allowing the patient to keep the sac empty and syringe at will.

A rapid improvement in both local and constitutional symptoms followed. Suppuration lessened; the sac gradually contracted until the catheter could not be retained.

The patient has fully regained her flesh and strength. Only a slight thickening can be felt to mark the place of the abscess.

May, 1868.

EPISTAXIS, FOLLOWING A BLOW ON THE NOSE FROM A BASE BALL.

By GEORGE DERRY, M.D.

APRIL 28th, 6, P.M.—Called to see a boy 14 years old, with violent epistaxis. History of case was as follows. Six days before, or on April 22d, he was struck by a base ball on the nose, fairly in front, and over nasal bones. There was free bleeding at the time, which stopped in about twenty minutes. During the five following days he went to school and played base ball as

usual. Had several bleedings during this period, but they seem to have been not violent, and the amount of blood lost not sufficient to prevent his exercising as usual. Several times on getting up in the morning a moderate bleeding occurred. On the afternoon of the day I was called, and six days from date of original injury, while playing base ball on the Common he bled profusely, fainted and was carried home. When I reached him he was still bleeding from left nostril. On filling left anterior nares with sponge, the bleeding was at once stopped. Next morning, at 7 o'clock, it recurred in spite of the sponge plug. I then carried a small bit of sponge moistened with sol. per sulphate iron as far into the nose as could be reached with dressing forceps, bringing it out again, and plugging left anterior nares with sponge and sol. per sulphate iron. The bleeding at once stopped. This plug remained in place 48 hours, being removed on the morning of May 1st. I then washed out the nares with a solution of tannin, and supposed all trouble was over, but took the precaution to have a Belloc's canula with posterior plug at hand ready for immediate use. That night at 11 o'clock I was summoned in haste. A temporary plug of sponge and iron, prepared for such an emergency, had checked the bleeding till my arrival. On removing this the hæmorrhage from left nostril was profuse, and distinctly arterial in color. I immediately plugged the posterior nares with dry sponge, and the anterior nares with sponge and per sulphate of iron. This stopped the bleeding effectually. Pulse 120 and feeble. Gave beef tea and wine at short intervals, and tinc. mur. ferri. Next day, May 2d, no bleeding, but great discomfort from tension on nose and cheek. May 3d, tension relieved in a degree by the escape of bloody serum through lachrymal duct into the internal angle of eye.

At the end of 74 hours from the time when plugs were last introduced, a small stream of fresh blood was observed trickling down the lip and cheek, and was traced to an opening at inner side of anterior plug. This was stopped by pressure with sponge. Partially decomposed serum and mucus continued, however, to ooze from the edges of plug. Dr. Hodges saw the case in consultation at this period, and with his concurrence the anterior plug was removed. It was followed by a stream of arterial blood. Sponge with per sulphate iron was immediately thrust into the nostril, but did not entirely control it as before. Dry sponge was then crowded in until the bleeding

ceased. Posterior plug not disturbed. Next day, May 6, plug was found to be gradually protruding, and at 3, A.M., of May 7, bleeding recommenced. Both plugs were at once removed, the posterior having become very offensive, after a retention of five days. The hemorrhage this time was less violent, and apparently not arterial. A sol. of carbolic acid, $\mathfrak{z}\text{i}$. to Oj . was syringed through the nasal cavity, with a view to clear it of decomposing material, preparatory to putting in a fresh posterior plug, but the hemorrhage diminished, and, by the application of ice, stopped in about 15 minutes. Communication with posterior nares being kept by means of a string on which was tied a plug ready to be drawn up at a moment's notice, the nasal cavity was now left exposed, and no more bleeding occurred. The young man was much reduced by this experience, but has now nearly recovered his strength.

The case seems to be singular and interesting from the fact that dangerous bleeding did not commence until six days after the reception of the injury, and then with great violence. It seems to me probable that a splinter was detached from one of the nasal bones, which by its pressure upon some considerable vessel, perhaps the nasal branch of the internal maxillary artery, caused the separation of a slough. There is, however, no visible deformity or displacement of any part of the nose.

No hemorrhagic tendency could be proved to exist in the family of the patient, and the blood at all times coagulated firmly. The father of the young man died from plegmonous erysipelas, following a wound of the palmar arch from broken glass, but not from hemorrhage.

Another observation which I would make with regard to this case is, that it seemed to me, although the styptic applications were temporarily useful, they were attended with certain disadvantages when used upon sponge and left in the bleeding cavity. The styptic quality of sponge itself, which depends upon the entanglement of coagula in its porous texture, was certainly diminished by the firm coating made by the iron upon its surface. After a retention for a day or two these sponges were covered with "clinkers" (so to speak), which prevented the penetration of the blood, and must have irritated, to a certain extent, the surface with which they were in contact. I would therefore advise, in a similar case, after a fair trial of iron styptics, to plug with dry sponge before and behind, and tie the two sponges together by a double thread passing from the posterior and over the anterior plug.

TREATMENT OF THE VOMITING IN COLIC.

Ms. Ennos.—The vomiting that so often occurs in colic, rendering its course so uncertain and protracted, led me, several years since, to seek a more prompt and reliable remedy than that usually employed. I used Dr. Mackintosh's tobacco injection, which, at first, seemed to answer the purpose. But its depressing, if not dangerous effects occasioned me to substitute tincture of lobelia, a safer yet equally efficacious agent. I had long found the tincture an invaluable remedy for the relief of constipation, used as an enema. One or two teaspoonsful in a quart of water thrown up the rectum will, in the early stage of colic, afford immediate relief.

But a more simple and efficient method of treatment of common colic may be found in the hypodermic injection of morphia. By dissolving one third or one half of a grain of acetate or sulphate of morphia in the smallest quantity of water, and injecting into the arm, the most certain relief may be obtained. If, however, after waiting ten or fifteen minutes, any pain should remain, the dose may be repeated.

During the last season, cases of cholera morbus were treated in a similar manner with success, though perhaps not in sufficient number to justify me in offering an opinion.

Were it necessary, many cases of colic might be adduced illustrating the benefits derived from the proposed method. A single case is sufficient.

A large, well-formed person was suddenly attacked with agonizing pain at the epigastrium, attended with retching and vomiting. Opiates were given and repeated; mustard was applied; enemata were used. Waiting several hours, with no amelioration of the symptoms, I then injected one half a grain of sulphate of morphia in the arm over the deltoid muscle. In ten minutes, the patient was perfectly tranquil. The next day, having had no recurrence of the paroxysm, she appeared well. No other remedies were given or required.

In the management of many similar cases during the past few years, I have had no occasion to resort to any other method than the one now proposed. The happy effects so frequently observed have induced me at this season of the year to submit these remarks, with the hope and expectation that others may be equally successful.

GEO. ATWOOD.

Fairhaven, July, 1868.

POISONING BY PENNYROYAL.

MR. EDITOR,—If you deem the following report of a case of poisoning from an overdose of pennyroyal, with symptoms similar to those produced by opium, of sufficient interest to occupy a place in your JOURNAL, please insert it.

I was called, near midnight, on the 16th of September, 1866, to see Mrs. L., aged 30 years, mother of two children. On entering the chamber, I perceived a strong odor of pennyroyal. Found Mrs. L. on the bed, in a comatose condition, from which I could not arouse her; breathing heavy, bordering on stertorous; pulse feeble and quick; extremities cool; skin damp; face pale, and muscles flaccid; her pupils were very much contracted and uninfluenced by light. Had great difficulty in getting anything into her stomach; was only successful by bringing her tongue well forward and carrying the spoon containing the liquid administered back into the pharynx. In this manner I gave an emetic and fifteen to twenty drops of fluid extract of belladonna every half hour. I will here remark that I had no stomach pump. After the expiration of two hours, the pupils began to dilate, followed in another hour by vomiting and return to consciousness when aroused. The vomited matter consisted of liquid smelling strongly of pennyroyal. The belladonna was now discontinued and strong coffee administered; the tendency to sleep continued. At 5, A.M., I allowed her to sleep undisturbed, from which I found her awakened on my return at 9, A.M., and learned from her that on retiring at 9, P.M., she had taken a teaspoonful of oil of pennyroyal (a bottle containing the same I found on a shelf in the room), in order to bring on her menses, which had been due several days, and that she had taken no opium or its preparations. Mr. L. went away after tea, leaving his wife at home, and on his return at 11, P.M., found her in bed asleep, in the same condition I found her. Her menses commenced on the 17th, and went through their usual course. She had considerable irritation of the stomach, which subsided in a few days. The symptoms being analogous to those arising from an overdose of opium, I at first attributed them to that cause, but after hearing her statement I could not do so.

Query.—Is there any case on record of oil of pennyroyal having produced similar toxic effects? Was recovery attributable to the influence of the belladonna?

W. A. WILCOX, M.D.

St. Louis, Mo., May 29, 1868.

Hospital Reports.

BOSTON CITY HOSPITAL.

Notes of Operations during the month of May, 1868.
Reported by FRANK W. DRAPER, House Surgeon.

CASE I.—*Dislocation of lower end of Tibia inwards; Reduction.*—(Service of Dr. GEO. DERBY.)—A. L. T., aged 47, while at work at his occupation as a carpenter, was thrown down by a falling beam. As he struck the floor on which he fell, he received upon the right leg, a few inches above the external malleolus, the full force of a blow from the beam, which in descending had grazed his shoulder. The deformity produced was characteristic; the foot was thrown outward and turned somewhat upward, and the internal malleolus appeared as a well-defined prominence, with a depression beneath. Immobility of the ankle-joint was complete. The fibula was not fractured.

The patient having been fully etherized, extension was made in the axis of the whole limb, but without success. The knee was then flexed at a right angle, and extension again made, the foot being at the same time rotated powerfully inwards. The luxation was reduced with a loud snap. Considerable pain and swelling ensued during the following week, but the recovery progressed well, and the patient was discharged on the fifteenth day after the injury, with only inconsiderable stiffness in the joint.

CASE II.—*Compound and Comminuted Fracture of Cranium; Trephining.*—(Service of Dr. GEO. DERBY.)—J. E. M., a boy four years of age, was playing, three quarters of an hour before entrance to hospital, about a building upon which masons were at work. A brick fell from the second story of the house, a distance of about twenty feet, and struck the boy directly on the vertex. A straight, perfectly regular scalp wound, an inch and a half long, was made in the median line, over the sagittal suture, its posterior extremity being about three fourths of an inch anterior to the apex of the lambdoidal suture. There was a wound of the pericranium sufficiently large to admit the tip of the little finger. Through this opening, a probe could detect denuded bone over a surface half an inch in each direction. A depression of the cranium was easily determined, of a regularly circular outline, with a diameter of 2 inches. The point most depressed was just beneath the wound in the scalp. The pupils of the eyes were equally and quite fully dilated, but were

readily acted on by light. The respiration was easy and natural. The patient was in a semi-conscious condition, but could be readily aroused, so that he would answer questions intelligibly. Pulse 104, full, but slightly irregular.

The patient having been etherized, the scalp was shaved, and the wound enlarged by incisions, so as to expose the injury. The fracture was found to be stellate, the point of greatest depression being in the sagittal suture, directly over the longitudinal sinus, and three eighths of an inch below the level of the surrounding bone. There was slight arterial hemorrhage from between the depressed fragments, at their lowest part. The trephine was applied in the sound parietal bone, and a small button removed just at the line of fracture. An attempt was made to elevate the depressed portions, but the fragments were perfectly wedged. The opening in the sound bone was enlarged by the removal of a small projecting point by means of a Hey's saw, and two large fragments of depressed bone were removed with a pair of ordinary wire pliers. The space thus uncovered was entirely at one side of the median line, and measured one inch and an eighth in breadth and two inches in length. A third fragment, on the opposite side of the sagittal suture, was allowed to remain, its immobility necessitating for its removal more force than it seemed justifiable to use.

The removal of the depressed portions exposed a considerable hemorrhage of mingled venous and arterial blood, from a small opening in the *dura mater*. This was effectually checked by a small sponge placed directly in the wound, and held in place by a roller bandage under the chin.

During the entire operation, the patient's pulse continued good. Recovery from etherization was ready, and without any nausea. No cerebral symptoms supervened, and the general condition was satisfactory.

During the early part of the next day, there was no change in the symptoms, consciousness remaining good, and no unfavorable appearances manifesting themselves. But towards the close of the day, an active fever was developed, with nausea and vomiting, rapid pulse and marked thirst. The pupils continued normal. At the twenty-fourth hour after the injury, there was a well-marked convulsion, confined entirely to the right side, the right upper and lower extremities being actively convulsed by regular tonic spasms. The face was undisturbed. As the convulsion passed away,

it was found that there was loss of motive power in the affected limbs, although there was well marked motion on exciting the reflex power by the application of ice to the palm and sole, or by tickling. Sensation in these limbs seemed unaffected. The muscles of the eye, face and tongue were normal, and the tongue protruded in the median line. The left side of the body was perfectly well, the disability being confined to the side opposite to that from which the pressure on the brain had been removed. Directly after the spasm passed off, its duration having been five minutes, the patient relapsed into a drowsy state, from which he was aroused without much difficulty.

Six hours later there was another convulsion like the first, but less marked. It was accompanied with free vomiting. The right leg, which had now lost its power of voluntary motion almost entirely, was warmer than the left, and this condition continued throughout the disease as long as paralysis lasted.

Meanwhile, the patient had taken milk quite freely, and was without pain. The wound was left alone, and no remedies were administered, save ice to allay the thirst. The pulse ranged from 128 to 150, and was generally regular and full. Intelligence remained perfect. The bowels were moved freely and voluntarily, and micturition was perfectly normal.

In the afternoon of the third day there was a recurrence of the fever of the day previous. The patient showed a decided disposition to sleep. No attempts were made to prevent this, and he was kept in a cool, darkened ward. Forty-five hours after the operation, the sponge was removed from the wound; the cranium and *dura mater* were perfectly clean and unirritated. Pulsation of the brain was very distinct. The flaps were partially apposed and retained by adhesive straps.

On the following day, suppuration commenced in the wound. The patient showed an obvious improvement. He was brighter, took notice of objects about him, and smiled on provocation. There was no fever; the pulse was 116 and regular. The pupils were still normal. The hemiplegic symptoms remained unchanged.

During the next five days there was no noteworthy change in the condition. The constant tendency was toward improvement. The patient lay quietly in bed, without pain or discomfort. There was a constant discharge of laudable pus from the scalp wound, and the denuded bone and membrane were slowly closing over with

healthy granulations. Milk was taken freely, and constituted the only diet. The patient slept well, and all the functions were regular. There was no apparent constitutional disturbance.

On the ninth day of the injury, a well marked *hernia cerebri* was developed, following prolonged mental agitation, with crying. When first seen it was of the size of a large pea, and it protruded from the surface of the *dura mater* just outside the boundary line of the longitudinal sinus, at the anterior part of the wound in the scalp. It pulsed very visibly, and any unusual excitement especially aroused the throbbing to a marked degree.

From this date onward, during the following five weeks, the only noteworthy change was in the appearance and development of this growth. There was a gradual improvement in the general condition of the patient. He ate well (bread and milk constituting his diet), and slept well. His intelligence, which, since the accident, had been rather less active than before, became brighter. The paralysis remained unchanged, not the slightest power of voluntary motion having been manifested. The reflex power was retained in very slight degree in the foot, but not at all in the affected hand. The sound limbs, as before, during the history of the case, were cooler than the paralyzed.

Meanwhile the hernia of the brain steadily developed, the patient lying all the time in a horizontal position in bed. In a month it had increased from the size of a small filbert to that of an English walnut. It was covered with healthy granulations, which produced a moderate amount of laudable pus daily. At times, the pulsations were very strong; they seemed to correspond in relative force with the state of the circulation in other parts of the body. On the thirty-ninth day after the injury, he was taken from bed, and supported in a chair in an upright position, by means of pillows. He sat in this position two hours; and, as a result, the change in the appearance of the tumor was very striking. It receded to a marked degree, its size being diminished the first day nearly one third. He was subsequently permitted to sit up a portion of each day, with manifest, though less marked improvement in the appearance of the hernia. The scalp wound, in the mean time, very slowly closed in from its edges, with healthy, but rather indolent granulations. The denuded bone was entirely covered in this way, but a probe, passed through the new growth, detected, beneath the surface of the parietal bone deprived

of its periosteum. No dressing was used, except a light compress over the wound, the accumulated discharges being daily cleansed by tepid water.

On the morning of the day, exactly six weeks from the time of the accident, it was observed that the relative temperature of the two lower extremities had changed, and the paralyzed limb was now cooler than the other. In the hands, there appeared no decided alteration. Six hours later, just six weeks from the hour of the convulsion which preceded the hemiplegia, the patient recovered power of motion in both the affected extremities, moving them both voluntarily, but having more control over the lower than the upper. The temperature in both sides of the body became now apparently the same, and has since continued so. With this unexpected gain, and with all the symptoms positively favorable, there seems to be a fair prospect of a good recovery.

Reports of Medical Societies.

NORFOLK DISTRICT MEDICAL SOCIETY OF MASSACHUSETTS. WM. H. CAMPBELL, M.D.,
SECRETARY PRO TEM.

A STATED quarterly meeting of the Norfolk District Medical Society was held at the Phoenix House, Dedham, July 8th, 1868, at 11, A.M., the President, Dr. Cotting, in the chair.

The records of the preceding meeting were read by the Secretary, Dr. Jarvis, and accepted.

Dr. A. LeB. Monroe, of Medway, read a paper on "Opium Antagonism," in which he reviewed the conflicting statements concerning the antagonism said to exist between opium and the Solanaceæ—especially belladonna. He showed that the theory was not a new one, and that there were good grounds, theoretically, for such a conclusion, but that in his experience he had never found any such antagonism to exist, therapeutically, and thought that he had seen harm done by administering one in the hope of counteracting the effect of the other. He advised that in case it was tried the doses given should be comparatively small and closely watched. He further remarked that it was difficult for him to understand how good and careful observers could, after making experiments, come to conclusions so totally different.

Dr. Martin, of Roxbury, said it was an

old idea that all substances which dilated the pupil would counteract the effects of opium, and that opium would counteract the poisonous effect of those that dilated it.

Dr. E. Stone, of Walpole, and Dr. Hazleton, of Mattapan, also made some remarks, all tending to cast doubt on the value of the one as a reliable antidote to the other.

The President read a paper, for Dr. Field, of Harrison Square, on "The Present State of the Tubercle Question," showing that this question is still *verring* some of the wisest in the profession at home and abroad; that while one prominent writer on tubercular inoculation asserts that "to doubt is now no longer possible," many are still unwilling to believe that tuberculosis can be induced by inoculation of tubercular matter with much if any more certainty than by the inoculation of other foreign substances, as, for instance, sulphur, cinabar, &c., as shown by Barignan in 1824, or fat as demonstrated by Behier in the recent discussions. Indeed, Prof. Behier declares that the question is still open, and requires other and more exact experiments before its study can be pursued with prospect of success. One of the extreme radical views now makes gray tubercle the only *true* tuberculous product, the yellow being due (according to this view) to a caseous transformation of venous products—generally those caused by chronic pneumonia. As yet, so far as the present discussion goes, the inoculability and the specific nature of the affection remain unsettled.

The President added, that some years ago an opinion was hazarded in this Society that "the causes of consumption are infinitely various," that "in the present state of our knowledge consumption seems to be a method designed to remove those whose mortal bodies have, from whatever cause, fallen below a normal condition," &c. This opinion, though harshly and unjustly denounced in high places as one which "if applied generally in the investigation of all diseases would forever check improvement in medical art"—this opinion receives much support in the course of the present discussion, and especially from Prof. Pidoux, who maintains that phthisis arises from internal or pathological causes, from common causes, and as the ultimate consequence of other diatheses, concluding with the impressive remark that "phthisis is not a disease which begins, it is a disease which finishes!"

And farther, evidence still accumulates

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of "the universal existence, prevalence, and inexorable progress" of the disease. Though there be a favorite theory in each locality for its existence (and these theories are as various as the places are numerous), it has been truly said, "it is evident that when a noxious cause is in power and predominates in a place, it is sufficient to originate and spread the evil there, but this is not a reason for denying or ignoring the influence of other causes, which in other places, together or singly, produce the same thing, as experience shows."

A few recent authorities were then cited, tending to show that many causes were at work in the product of tuberculosis; and that people died of it in all climates and in all sorts of circumstances.

Dr. Martin said that, in confirmation of the view that phthisis might be designed to remove the weak and otherwise degenerated, he would mention his own observations among hybrid races. He found tuberculosis vastly more common and more destructive among the mulattoes, for instance, in North Carolina and in the South Western States, than among the pure blooded of either the white or the black race in the same localities. He said further, that men who entered the army in the hope of recovering from the disease, often improved very much, if the disease had not gone too far, through the good effects of out-door life and air.

Dr. Hazleton said that he had spent several months on the west coast of South America, and that at Lima, where it is said never to rain, the disease in question is very rife. There were, however, some small places, near by, where it was said patients recovered from it. The inhabitants are mostly mixed races of Indians, descendants of ancient Peruvians, and Spaniards.

Drs. Jarvis, of Dorchester, and Bacon, of Sharon, offered interesting remarks on the subject, to nearly the same effect.

After a short recess for dinner, the subject assigned for discussion was taken up, viz., "The Standard of Medical Education."

Dr. Campbell, of Roxbury, one of the appointed disputants, read a paper, in which he said that the faculties of colleges, standing as it were in the focus of the subject, could hardly be expected to see it in the same light as those do who are farther removed; but that from the point which he occupied it seemed as if all was done that could be to increase the *number* of students, without regard to personal capacity or attainments, or the wants of the community. And from this cause doctors were made too

easily for the good of the profession, might he not say, of the public. To remedy defects in medical education, it had been proposed to increase the length of the lecture term, to multiply the number of lectures in a term, and to increase the number of terms; but he thought the true remedy was a thorough examination *before matriculation*, to see that the student was well up to the standard of preparation now required, as it was seldom known whether the student was up to that standard or not. He spoke also of the relation of student to tutor, and said that certificates of study often came from men who had never imparted one word of instruction to the pupil, and even from men who had no authority to give such certificates. He thought that the student should labor with his preceptor, and learn the art by assisting in the practice of it from day to day. To sum up, he thought the proper course would be—

1st, To guard the entrance to the profession, and admit none to the medical classes who were not properly qualified.

2d, To insist on three full courses of instruction, such as that, for instance, now given in the Harvard Medical School, with the understanding that strict attendance on the lectures, the hospital, and other practice, will be required; and

3d, That at least one year shall be spent in practice under the direction of a good practitioner—in short, a year's apprenticeship.

Dr. Waldo, of Roxbury, also read a paper, in which he claimed that the examination for degrees was not thorough enough, and that the admission to the profession of so many not thoroughly prepared was an injustice to those already in.

Dr. Martin thought that it was a matter of pecuniary interest to professors to have large classes, and that while that was the case there was little hope of reform, and advocated a national college, with professors paid a fixed salary without regard to the number of students.

Dr. Jarvis thought that the standard of medical education had risen very much since he left college, and that altogether we had better men coming out now than at that time.

Dr. Waldo thought that what was needed was a centralization of the power to grant diplomas, and a discouragement of small colleges.

Dr. Campbell suggested that the only way to arrive at any good result was to agitate the matter before the State and County Societies, as practitioners were

really the persons most affected by the present system. It was their place to lend an active hand. State legislatures would do nothing to check the evil, and the colleges had done nothing practically.

Dr. Bacon reported a case of puerperal convulsions. The patient, a primipara at the sixth month of pregnancy, after a long sleighride on an excessively cold day, was taken with a feeling of vertigo, which was soon followed by coma. After the ineffectual use of chloroform and venesection, when between twenty and thirty fits had occurred, labor was induced. After this the convulsions became less violent and less frequent, but she died without return of consciousness.

Dr. Bacon said he would like to know what the members thought of the course pursued, as it had been said by a physician, at the time, that labor should not have been induced, but left to itself, and the disease combated in some other way.

Dr. Martin thought that if there was any blame, it was in not delivering soon enough.

Dr. Bacon said that was his own opinion; and, on his motion, it was *voted* that the subject for discussion at the next meeting of the Society be *Puerperal Convulsions*.

At 3½, P.M., adjourned.

Bibliographical Notices.

A Practical Treatise on the Diseases of Children. By D. FRANCIS CONDIE, M.D., Fellow of the College of Physicians, &c. Sixth Edition, revised and enlarged. Philadelphia: Henry C. Lea. 1868.

Dr. CONDIE's work may be fairly considered a standard authority on the important class of diseases on which it treats. Writing from an extended practice of his own, he has also taken special pains to cite everything of importance that he could find in the works of other writers on the subjects of which he treats. These citations form a very valuable feature in the work, many of them being quite recent. The views of others, especially when differing from those held by the author, are given with great fairness, and all superfluous hypothetical reasoning has been excluded as far as possible, the aim having been to render the work, in the words of the title, "A Practical Treatise." In this he has certainly succeeded, and the number of the present edition shows that the profes-

sion are not insensible to its solid value. We cordially recommend it as a safe and wise counsellor, especially to the young and more inexperienced of our professional brethren. The book is printed in a large and clear type, very agreeable to the eye.

Obstetric Clinic: A Practical Contribution to the Study of Obstetrics and the Diseases of Women and Children. By GEORGE T. ELLIOT, Jr., M.D., Professor of Obstetrics and the Diseases of Women and Children in the Bellevue Hospital Medical College, Physician to Bellevue Hospital, and to the New York Lying-in Asylum, &c. &c. New York: D. Appleton & Co. 1868.

The plan of Dr. Elliot's work is a most excellent one, and no one is more competent for the duty which he proposed for himself in undertaking it. After a service of fourteen years in Bellevue Hospital, during which he had been most diligent as a clinical instructor, he determined, at the commencement of his service in the spring of 1867, to make the most interesting cases which might come under his observation the basis for a volume of strictly clinical character, but which should also contain a general exposition of his views on obstetrical questions, illustrated by the cases which had accumulated on his hands or had been published in journals not easy of access. This plan enabled him to give to the book, to a considerable extent, the style and phraseology of a lecture, each chapter beginning with cases occurring in his hospital service, which serve as texts for the chapter. The result is a series of chapters on some of the most important subjects connected with midwifery, such as Albuminuria in its relations to Pregnancy; the Prophylaxis of Puerperal Eclampsia, its Varieties and the various Methods of treating it; the Relations of Epilepsy to the Puerperal State, and Puerperal Mania; Ante-partum and Post-partum Hemorrhage; the Induction of Labor; several of the Mal-presentations in Labor, with Rupture of the Uterus; Deformed Pelvis in its relations to Labor and the Artificial Delivery in these Cases; Version; Inflammatory Complications in treating the Diseases of Women; Abnormal Conditions of the Bladder in Women; Compression of the Funis; and Retropharyngeal Abscess. Each subject is illustrated by cases, many of which are of extreme interest, and the record of the fatal ones is completed by a report of the autopsy when it could be obtained. The style of the book is eminently attractive, and calculated to

impress its teachings most forcibly upon the reader. As a whole, we know of no similar work which has issued from the American press which can be compared with it. It ought to be in the hands of every practitioner of midwifery in the country. The typography of the work is the perfection of elegance. Messrs. Lee & Shepherd have it for sale. A.

Medical and Surgical Journal.

BOSTON: THURSDAY, JULY 23, 1868.

THE DUTIES OF HOSPITAL PHYSICIANS AND SURGEONS.

THE past week has been signalized to our medical community by the opening of a new pavilion in the Carney Hospital, at South Boston. This will add a very considerable number to the beds for the sick furnished by charity in our midst; and ultimately, no doubt, will be followed by a larger increase, both there and elsewhere.

The professional field must again be gleaned to furnish a medical and surgical staff; and the choice will doubtless fall, in part at least, on some of the younger members of the body medical.

Far be it from us to say that the young men will not make the most efficient officers. But the whole question of the increase of charity medicine, and of the rights and duties of medical men in connection with such institutions, is so important, that our readers can well afford to spend a few minutes in its consideration.

The needless increase of free dispensary and hospital treatment is an abuse. It is a vital injury to the young physician, who must live on the small fees obtainable from just those middling classes of the community whom the dispensary system invites to a gratuitous treatment.

We hold it, therefore, to be strictly the duty of the dispensary physician, or the physician to out-patients at a hospital, to distinguish carefully between those applicants who should pay something and those who cannot; and either to exclude the former, or to enforce the payment of suitable fees for the support of the charity which is to feed the poorest class.

We hold, also, that it is the right and duty of the hospital staff to be paid for their services, a moderate salary; not in proportion to the work they do, for no hospital could afford that; but just enough to furnish an acknowledgment of the fact that their services are recognized and compensated.

Such a claim could not be considered venal or narrow on the part of our profession, unequalled and unapproached by any calling in life in the amount of gratuitous service it unavoidably and cheerfully renders to the world.

In the second place, we would say a word on the *duties* of the hospital staff.

Their first duty is to the hospital patients; to treat them as kindly and as patiently as their private *clients*. And so, to their honor be it spoken, we believe they almost universally do. And we trust that the day is far distant when the customs of some parts of Europe shall be introduced among us, and the human being be lost sight of in the morbid interest of his case.

But the next and farther duty of the hospital physician is to the profession, to knowledge, and to students in medicine. It is his duty to demonstrate his cases; to impart his experience; to teach clinically all who choose to hear him. He is practically put in the position of a law-giver to his brethren. From our hospitals emanate the doctrines, the experience which guide us all. There only is the opportunity afforded of treating disease uniformly and on a large scale, remote from the disquietude and interruptions of friends and of the patient himself. And, more particularly, in our day, is the superlative importance of clinical teaching recognized and valued.

Modern custom brings together in our cities large classes of young men, who come to study medicine where clinical facilities are freely furnished. Every motive both of private interest and public welfare appeals to our hospital staffs to make the most of their facilities in instructing others and in striving to make our city what it might be, but what it has not been hitherto, a true medical centre, unsurpassed in this country.

DEATH FROM CHLOROFORM.—KOHNEIM'S NEW VIEWS.—We are permitted to quote the following from a private letter. Our readers will recall the very full *résumé* of Kohnheim's researches on the transudation of the white blood-cells, given in late numbers of the JOURNAL.

"One of Bilroth's patients died the other day under chloroform. The case was one of simple injury to the hand, and chloroform was given in order to facilitate the examination; the patient quietly ceased to breathe, and an immediate tracheotomy failed to help him. Another case, illustrating the great occasional danger from this anæsthetic, I saw in Braun's clinique. It was a removal of a fibrous tumor from the uterus, and the patient was with the greatest possible difficulty saved.

"What a change Kohnheim's new theory of the passage of the white blood corpuscle through the coats of the vessel, has made in pathology! Virchow seems to be supplanted by his pupil, and the third edition of Bilroth's Surgical Pathology shows great changes from the second." R. H. D.

FORMATION OF FAT FROM FLESH.—If any thing were wanting to show the imperfect condition of our knowledge even of those sciences in which rational medicine is presumed to have its foundation, the results of Professor Pettenkofer's recent inquiries would supply all that the most determined sceptic could desire. To be told, after all we have learned of physiological chemistry, that fats can be formed in the body as the result of a chemical metamorphosis of pure albuminoid matter, is enough to shake the faith even of the most orthodox. Yet this is what Herr Pettenkofer announces as the conclusion arrived at from a long series of practical experiments and scientific reasonings. Doubtless there are many who will look upon the new doctrine as one without a shadow of probability; and we confess it would be difficult to find fault with such. But a little reflection and a consideration of the phenomena involved in the production of that well-known and remarkable substance adipocere (or bog-butter) will tend to clear a way to the admission of the startling proposition which comes to us from the Royal Laboratory of Munich.

Herren Voit and Pettenkofer, in publishing a result which must materially modify the laws of physiology and hygiene, urge as a farther illustration of what they have

demonstrated as a scientific problem, the familiar instances of the sucking pig and the wax of the common bee-hive. Here, they say, we have the existence of definite fatty substances whose quantity is infinitely greater than that contained in the material from which it is obtained. As a mere chemical illustration of the force of their views, they refer to the development of fatty acids in the decomposition of ordinary albumen. These, say the Bavarian chemists, are striking indications of the possibility of converting albuminous substances into fat, and yet physiologists have overlooked them in their acceptance of a theory of the formation of fat from hydrocarbons—a theory which is absolutely undemonstrable. But as hypothetical argument meets with little favor from practical men, and as the *experimentum crucis* is looked to as the highest test of a sound empiricism, we shall lay before our readers some of the very singular experiments which have been conducted by Professors Pettenkofer and Voit.

The first animals selected for experiment were dogs, and others were submitted to a starchy diet; but what were the results? The dogs fed upon albumen absolutely fattened upon it, and fatty matter was found in their excretions. Those, on the other hand, whose diet had been starchy never fattened at all. A nursing bitch was next selected for experiment. She was fed upon several varieties of food, but was found to form the greatest quantity of fat from pure flesh; indeed, when she was fed upon a mixed diet of flesh and hydrocarbons, it was discovered that the quantity of fat and sugar in her milk had sensibly diminished. An objection to the conclusions drawn from these inquiries—at least so far as they refer to man—might be found in the fact that carnivorous animals may differ from omnivorous with regard to the physiology of digestion; but this objection would, we apprehend, be more apparent than real.

However, even on this point the opponents of the new hypothesis would be fully met by the experiment we are now about to detail. A milch cow having been set apart for observation, she was watched from hour to hour for a period of a week by Herr Voit's assistants, and the urine having been carefully collected, the results given below were arrived at, and for their accuracy Herr Voit pledges his reputation as a chemist.

"In the course of six days the cow consumed in meal (?) and hay 1407 grammes of nitrogen, and eliminated 1440 grammes in the urine, excrements, and milk, the dif-

ference thus corresponding to about 2 per cent. In the 80.6 kilogrammes of hay and the 14.7 kilogrammes of meal there were 2663 grammes of fatty matter; 1044 grammes were found in the excrements, and consequently 1619 grammes were introduced into the circulation. In the urine, weighing 178 kilogrammes, were found 562.4 grammes of nitrogen. If we calculate the quantity of corresponding albumen, and the quantity of carbon contained in this albumen, we find that the latter is equivalent to 2220 grammes of fat, which it is necessary to reduce to 2120 only, because 4.5 per cent. of the carbon remains united to the oxygen after decomposition of the albumen. The 57.3 kilogrammes of milk contained 1877 grammes of albuminoid substances, 1976 grammes of fat, and 3177 grammes of sugar. The albumen in the body may thus produce 144 grammes of fat more than is found in the milk. Now, the carbon of the sugar of milk corresponds to 1670 grammes of fat, whilst the 144 grammes in question, added to the 1619 of the food, make a total of 1763."

The immense difference between the ingested and egested fat shows clearly enough that it is not necessary to have recourse to the hydrocarbon theory to account for the development of fat in the body. "Consequently (say the Munich *savants*) it is extremely probable that, even in herbivora, hydrocarbons do not furnish matter for the formation of fat, but allow of its development by being consumed, and thus supplying what it would otherwise provide for." Whatever may be the ultimate decision, as regards these surprising results, one thing is certain—the hypothesis which has been promulgated by Herren Pettenkofer and Voit is one of the highest interest to the physiological chemist, and one which must leave its mark on the physiology and practical medicine of the future.—*Med. Times and Gazette*.

OVARITOMY.—DR. PEASLEE exhibited, at the New York Pathological Society, an ovarian tumor, and remarked upon it as follows:—

"I have brought this here for the sake of showing an interesting point in diagnosis, as I thought it would prove to the Society, and not because of any interest that may be possessed by the tumor itself. It is an ovarian tumor removed from a woman some hours after death, and hence has no interest in connection with an operation. This patient I first saw four weeks ago, she hav-

ing been tapped eighteen times, and there having been removed from thirty to sixty pounds of fluid at the different tapplings. She had always rallied after these without symptoms of inflammation, but she was not then in a condition for a removal of the tumor, and if she had been, I should have first preferred, as I always do (unless there is some particular reason to the contrary), to tap her once myself in order to perfect the diagnosis. This diagnosis, I may say, remained somewhat doubtful. She had been tapped by two different physicians, and so far as I could learn no decided opinions as to the precise nature of the tumor had been expressed. I found the circumference of the abdomen about forty inches. The appearances presented were those of a monocystic ovarian tumor. Examining her per vaginam, I felt a very solid, unresisting mass projecting into the pelvis. Fluctuation through the abdominal wall was very distinct; the uterus was in the natural position, and the sound passed in to the natural extent, two and a half inches. (I may mention here that she had given birth to one child.) I regarded the tumor as ovarian, tapped her, and drew off 60 pounds of fluid from a single sac. The remaining portion of the mass that I felt in the pelvis per vaginam was then brought into view. I then examined the woman with a sound to ascertain whether, after all, this might not be a fibro-cystic tumor of the uterus. I could introduce the sound, and hold the uterus up above the symphysis pubis, and make it so prominent that I could take it in my hand and feel every portion of it distinctly. I could feel the fundus of the organ and the pedicle of the tumor separated from it and extending into the mass, giving a perfect demonstration that it could not be a fibro-cystic uterine tumor. The pedicle, as seen here, is about two inches in depth and very delicate. I proposed, after the tapping, to await the result of her refilling, which I concluded would be in about three weeks, when I should be prepared to remove the tumor. She went on for five or six days, when she was seized with a bilious attack, and vomited a great deal. This reduced her considerably; but she recovered, to be attacked a week afterwards by bronchitis, from which she sank.

This sac, on examination, presents some interesting points. It appears to be extremely thick, but the least traction will tear it. That thickness is apparently the result of successive inflammations; still she never complained of any of the usual symptoms of such a complication during life.

The sac is lined throughout by a soft pulpy exudation, which makes up more than half of the thickness of the sac itself. You see here whence proceed these long strings of exudation which so frequently block up the catheter during an operation, yet, strange to say, in this instance nothing but a highly albuminous viscid fluid escaped through the canula.—*N. Y. Medical Record.*

DISLOCATION BACKWARDS OF THE RIGHT RADIUS AND ULNA, THE FOREARM BEING IN THE POSITION OF EXTREME EXTENSION.—Dr. Helm reports the case in the *Lancet*.

A—, on February 22d, 1867, fell, when jumping, and injured his right arm. Thinks he has broken it. When I saw him, he was lying on a bed, the arm being extended on a pillow, with the hand pronated, and the forearm extended on the humerus beyond the straight line, so as to produce a bowed appearance, which immediately attracted my attention. The olecranon could be seen projecting under the skin at the posterior surface of the upper arm, giving the limb a very deformed look, by reason of its position at a point considerably higher up the arm than that which the fold in the skin anteriorly pointed to as the natural position of the elbow-joint; so that the upper arm looked of a natural length and form when viewed anteriorly, but very short and deformed when viewed from behind. The head of the radius could be distinctly felt behind the humerus, and considerably above the outer condyle, which could not be felt, though its position could, of course, be inferred from that of the internal condyle, which was very distinct. The olecranon must have been quite two inches higher up the arm than is natural in the state of extension. There did not appear to be any separation of the bones of the forearm, the radius retaining its relative position to the ulna; and the lower end of the humerus could be felt projecting in front. There was very little swelling of the soft parts, and I was unable to detect any fracture, though the reduction of the dislocation, easily accomplished over my knee by reason of the faintness of the patient, was attended by a very disagreeable grating sound, unlike what is heard in the reduction of most dislocations. An angular splint was loosely applied.

March 6th.—No bad symptom; motion perfectly restored. Was seen to-day by Sir Wm. Fergusson, who could scarcely believe that the joint had been so severely injured, so sound was it and well.

REMARKS.—The above is a case of the or-

dinary dislocation backwards of the forearm, with the single exception of the limb being extended instead of more or less flexed. This arose, I think, from the great distance which the olecranon was drawn up the posterior surface of the humerus; and it is only on the supposition that, in this case, the triceps muscle from some cause had it all its own way, and, by reason of its sudden and powerful contraction, aided, perhaps, by the position of the arm at the time of the accident, was enabled to draw the olecranon so far up the back of the shaft of the humerus, that the position of the bones can be accounted for. The forearm could not have assumed the position it did unless the coronoid process of the dislocated ulna had, with the permission of the flexor muscles of the forearm, cleared the olecranon fossa; for this process and the flexor muscles, the one by fitting in a measure into the olecranon fossa, whilst the surface below was across the lower end of the humerus, and the others by their strength of resistance and contraction, would almost necessitate that the bones should, as they usually do, form an angle with the humerus. But when the coronoid process is drawn such a distance up the shaft of the humerus that it is above the level of the olecranon fossa, then there is every reason why—the flexor muscles permitting—it should rest against the posterior and inner aspects of the humerus, under which circumstances the position of the extension must occur, just as much so as one of flexion does in cases where there is a less amount of dislocation. Looked at in this light, the amount of extension is an index of the extent of the dislocation.

DETECTION OF ARSENIC IN CASES OF POISONING.—M. Buchner has several times recognized the presence of sulphide of arsenic in the bodies of persons poisoned by arsenious acid. Certainly this fact has never been observed except where the corpse has been in a more or less advanced state of putrefaction; the sulphurization would appear to be due to sulphuretted hydrogen, a constant product of putrefactive decomposition. The last observation upon this point M. Buchner has made, was upon the remains of a woman who had been poisoned eleven months previously. The large intestine was in full decomposition, and there were yellow marks upon the mucous membrane, caused by a fine powder which could be removed by washing. This powder resembled the yellow deposit which is produced in arsenical solutions by sulphuretted hydrogen; further, it gave the characteristic

reactions of sulphide of arsenic. Examining now whether the arsenic had been administered as sulphide, he concluded in the negative, for the following reasons: The contents of the stomach and small intestine being boiled with hydrochloric acid, and the vapors from the distillation of the acid collected in water, in a few minutes a quantity of chloride of arsenic was obtained; such would not have been the case with sulphide of arsenic, notwithstanding that this sulphide is not absolutely unacted upon by boiling concentrated hydrochloric acid. The sulphide of arsenic being insoluble in pure water and in acidulated water, it would not be carried into the circulation, also it would not be found in the liver and spleen, both of which in this particular case were saturated with arsenic. A part of the stomach and small intestine cut up and placed in the dialyser with water acidulated with hydrochloric acid, gave at the end of twenty-four hours a solution containing arsenious acid in sensible proportion, a fact proving that all the arsenic had not passed into the state of sulphide.—*Chemical News.*

SPIRITUALISM OUTDONE.—In the good old times, when it was the fashion to burn witches, it is probable that in many a case a coincidence of physical and mental causes, such as we are about to mention, may have had the effect of bringing a spiteful old crone to the stake. It appears that at the Limerick Sessions two men were charged with having assaulted a relative. The prosecutor summoned his own father as a witness. The mother of the prisoners, exasperated at the prospect of her sons being sent to prison on the evidence of her own relative, gave expression to her feelings in a malediction, praying that when the old man left the witness box he might be paralyzed, and paralyzed he was accordingly, and had to be taken to Hospital. Such miraculous illness not yielding readily to ordinary modes of treatment, the old lady has been requested to remove her curse by spitting on the patient; but this she sternly refuses to do, and the man remains in Hospital. This beats modern spiritualism hollow. If Mr. Home and his disciples could only produce a few such striking effects, there are many persons, whom the most rigorous scientific investigation would fail to convince, "contrary to the evidence of their own senses," that the connection between cause and effect is something more definite and invariable than the chance link which, in illogical minds, gives to a coincidence the factitious value of an effect.—*Med. Times and Gazette.*

Selections and Medical Items.

QUADRUPLE BIRTHS.—Dr. Geo. M. Mayberry, of Riversdale, Kenmare, reports the case of Margaret Gallivan, laborer's wife, æt. 33, multipara, of delicate and emaciated appearance, who gave birth, on February 7, 9 and 10, to four children—one son and three daughters—all alive. The entire delivery was accomplished with no interference, save that of rupturing the membranes. The mother's debility was exceedingly great, but she has now entirely recovered. The first child lived 8 hours; the second, 60; the third, 44; and the fourth, 16. The Queen sent a donation of £4 to the sufferer.—*Med. Press and Circular.*

CONGENITAL ANORCHIDIA.—Dr. Wenzel Gruber has published in the *Med. Jahrb.*, December, 1867, a valuable essay "On Congenital Anorchidia in Man," wherein will be found an abstract of all the cases observed for the last 300 years. From recorded post-mortem examinations, Dr. Gruber finds twenty-nine reliable cases of congenital anorchidia; out of these there were twenty-two cases of monorchidia, and seven or eight cases of anorchidia on both sides. He adds a description of two cases of his own: one of anorchidia on one side, the other of double anorchidia.

M. REICHERT has devised a new method of preparing magnesium. He takes 1,000 grammes of the anhydrous double chloride of magnesium and potassium, pulverizes it, and mixes it with 100 grammes of finely powdered fluor spar; this mixture is fused with 100 grammes of sodium. The compound proposed for use occurs in the mineral kingdom in tolerable abundance as carnallite. White pieces of this mineral are available and require no previous treatment; colored fragments must be dissolved in water, the impurities allowed to settle, and the lixivium evaporated.—*Chemical News.*

NEURIN AND SINICALIN.—Claus and Keese have made some experiments on sinicalin with a view of elucidating the nature of its relation to neurin. After a careful comparison of the various derivatives of the two, particularly of the chloro-platinate and aurate, the authors come to the conclusion that they are identical.—*Journ. pr. Chem.*

A NEW ANODYNE.—Dr. A. H. Gallatin, of this city, communicates the following: Having a case where the oxide of zinc and bromide of potassium had failed in producing sleep, and where the cerebral symptoms prevented the exhibition of any preparation of opium, I thought of trying a combination of codeia, ipecacuanha, and sulphate of potash, in imitation of pulv. Doveri. The result satisfied my theoretical expectations. Morphia, codeia, and perhaps other alkaloid extractions of opium are now universally used, when the narcotic without the stimulating effects are to be produced. By combining these principles with ipecacuanha, I think I have provided a mixture which may be given in cases where it would not be judicious to use pulv. Doveri.

Several members of the faculty are at present

trying this mixture in their practice, at my suggestion. I hope soon to give an account of the result.—*N. Y. Medical Record.*

ACTION OF VERATRIA.—Dr. L. Hirt, of Breslau, has arrived at the following conclusions, after experimenting with veratria: 1st. Poisoning by veratria diminishes the intensity of the respiration and of the circulation. 2d. The muscles lose their tension. 3d. The sensibility of the peripheral nerves is diminished. 4th. Small doses produce nausea, vomiting, and diarrhœa. 5th. The secretion of urine is slightly, that of saliva markedly, increased.—*Ibid.*

MUSHROOMS IN THE EAR.—Two new kinds of mushrooms of the *Aspergillus* order, growing on the membrane of the tympanum, are described by Dr. C. Robin, in a paper read to the French Academy of Sciences. This parasitical vegetation he has observed in ten patients, four of whom had it in both ears; and in all cases it existed independently of any other morbid affection.

This auricular mushroom presents the botanical characteristics of *aspergillus glaucus*. He has found that these *aspergilli* can exist elsewhere than on the human body; as they take to the lemon or orange very readily; but their color is lost by the transfer. The growth of these parasites in the human body is an obstinate affection, and Dr. Robin gives highly diluted solutions of hydrochloride of lime or of arsenite of potash, which at once destroy the cells of the *aspergillus*.—*Ibid.*

MEDICAL DIARY OF THE WEEK.

MONDAY, 9 A.M., Massachusetts General Hospital, Med. Clinic; 10 A.M., Medical Lecture. 9 A.M., City Hospital, Ophthalmic Clinic.

TUESDAY, 9 A.M., City Hospital, Medical Clinic; 10 A.M., Medical Lecture. 9 to 11 A.M., Boston Dispensary. 10-11 A.M., Massachusetts Eye and Ear Infirmary.

WEDNESDAY, 10 A.M., Massachusetts General Hospital Surgical Visit. 11 A.M., OPERATIONS.

THURSDAY, 11 A.M., Massachusetts General Hospital Clinical Surgical Lecture.

FRIDAY, 9 A.M., City Hospital, Ophthalmic Clinic; 10 A.M., Surgical Visit; 11 A.M., OPERATIONS. 9 to 11 A.M., Boston Dispensary.

SATURDAY, 10 A.M., Massachusetts General Hospital Surgical Visit; 11 A.M., OPERATIONS.

TO CORRESPONDENTS.—Communication accepted:—Section of Ciliary Nerve, &c., for Sympathetic Ophthalmia.

DEATHS IN BOSTON for the week ending Saturday noon, July 18th, 1862. Males, 60—Females, 42.—Ab-scess, 1—accident, 3—disease of the bladder, 1—inflam-mation of the bowels, 1—inflammation of the brain, 1—congestion of the brain, 1—disease of the brain, 4—bron-chitis, 4—cancer, 1—cholera, 1—cholera infantum, 14—consumption, 6—convulsions, 3—croup, 1—debility, 2—diarrhœa, 2—erysipelas, 1—intermittent fever, 1—scarlet fever, 4—typhoid fever, 2—disease of the heart, 1—dis-ease of the liver, 2—congestion of the lungs, 1—inflam-mation of the lungs, 5—marasmus, 2—measles, 7—old age, 3—paralysis, 2—peritonitis, 1—premature birth, 3—puerperal disease, 1—scrofula, 2—sunstroke, 7—teething, 2—unknown, 6—whooping cough, 2—inflammation of the womb, 1.

Under 5 years of age, 58—between 5 and 20 years, 6—between 20 and 40 years, 16—between 40 and 60 years, 13—above 60 years, 9. Born in the United States, 80—Ireland, 15—other places, 7.